Hirst

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BY

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A COINCIDENT INTRA-UTERINE AND EXTRA-UTERINE PREGNANCY—TWO CASES OF OBLIQUELY-CONTRACTED PELVIS—THE PRIMARY REPAIR OF A LACERATED PERINEUM—STRICTURE OF THE RECTUM FOLLOWING A WHITE-HEAD OPERATION FOR HEMORRHOIDS.[1]

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COINCIDENT INTRA-UTERINE AND EXTRA-UTERINE PREGNANCY.

GENTLEMEN: The specimen of a tubal pregnancy that I here present to you was removed a few weeks ago, by abdominal section, from a young woman with a peculiar history. Just four weeks before I saw her she had induced abortion on herself at the fourth month of gestation, by passing into the womb this rubber catheter and its steel stylet that she had bought at a drug-store. Profuse hemorrhage followed, and a few hours later the fetus was discharged. She saw it plainly, distinguished its limbs, trunk, head and face, and from her unprompted description of its development and length it corresponded with the date that she believed pregnancy had reached. She threw the fetus and its placenta down a water-closet. Shortly after the delivery the woman was seized with

[1] Abstracts from clinical lectures at the Philadelphia Hospital.

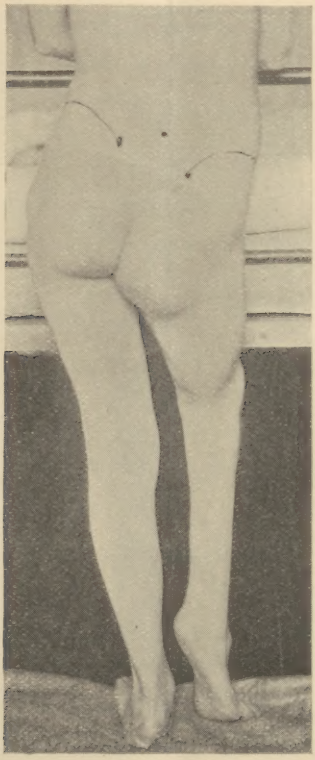
abdominal pains that increased steadily in severity until she was forced to go to bed. When I first saw her I found the temperature 103°, the pulse rapid and feeble, the abdomen tympanitic and exquisitely sensitive. On vaginal examination, large, tender masses were felt behind and to the right side of the uterus. I concluded, naturally enough, that I had to deal with a case of a common kind in this hospital—septic infection of pelvic tissues from criminally induced abortion. The abdomen was opened the following day, when, to my surprise, I found the conditions characteristic of tubal pregnancy and no sign whatever of septic inflammation. Old clots and a quantity of black blood welled out as soon as the peritoneum was incised, and on removing the right tube a gestation-sac of from six to eight weeks' development was found in it, without an embryo, but with the chorial villi so well developed and so evident that, as you see, there is no mistaking the character of the mass within the tube. Here is an extra-uterine pregnancy that never could have been diagnosticated or even suspected before operation. The intra-uterine pregnancy that must have coexisted with it and the induced abortion completely masked its symptoms. The patient has made a perfect recovery.

OBLIQUELY CONTRACTED PELVIS.

I cannot present to you the next two patients in the flesh, for they are inmates of other hospitals, but I show you their photographs, which are quite as instructive. Figs. 1 and 2 show the pelvis of a young primigravida recently delivered in the Maternity Hospital, under the charge of my friend Dr. Robert H. Hamill, who kindly permitted me to examine her. The girl had developed tuberculous disease of the right knee-joint at the early age of three months. Ankylosis of the joint and atrophy of the limb followed, so that from the time of the first attempts to walk the greater part of the weight of the trunk has been supported by the sound

leg. As always happens in such cases, the corresponding innominate bone is displaced backward, upward, and inward, encroaching to some degree upon the

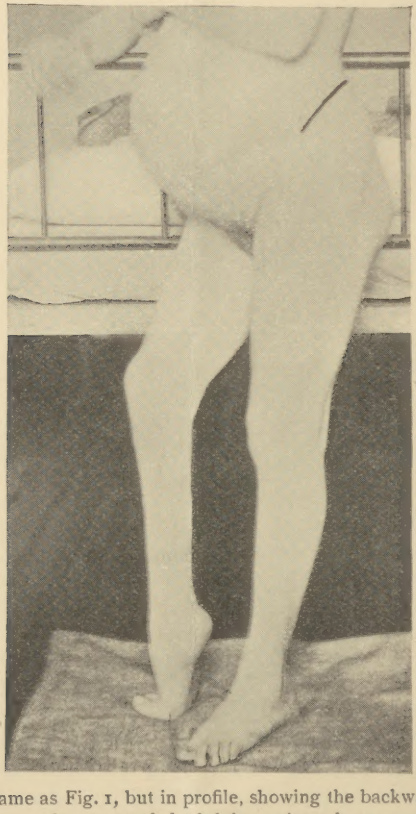
FIG. 1.



An obliquely deformed pelvis. (The lines follow the crests of the ilia; the central dot corresponds with the depression below the spinous process of the last lumbar vertebra.)

area of intra-pelvic space and distorting the shape of the pelvic inlet and canal. The direction of the pelvic canal, too, is altered. The inlet is directed to the un-

FIG. 2.



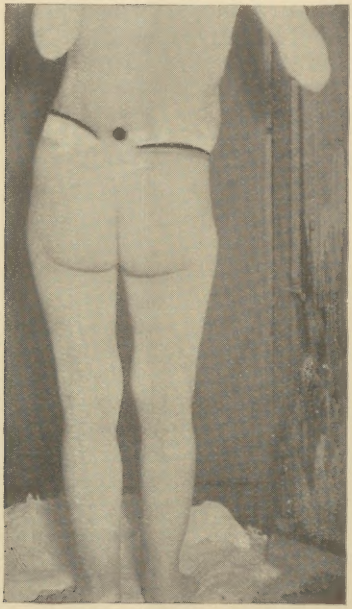
The same as Fig. 1, but in profile, showing the backward displacement of the left innominate bone.

sound side; the outlet toward the sound side. The best known example of this deformity is the unique case described by Mme. LaChapelle, of a young woman who had always borne the weight of the trunk entirely upon one leg, the other being absent. The pelvis was so distorted in consequence that labor was very difficult. I have learned from experience, however, that ordinarily simple, oblique distortion of the pelvis, without atrophy of the sacral ala and ankylosis of the sacro-iliac joint, as in a true Naegele pelvis, is not to be feared. On the other hand, even a slight oblique distortion, along with other pelvic deformity, such as antero-posterior or lateral contraction, is to be dreaded. Cases in the former category may exhibit some slight abnormality in pregnancy or some unimportant anomaly in the mechanism of labor, but the result is usually fortunate. The history of my case bears out this statement. The woman had backward displacement of the womb, and symptoms of incarceration and dysuria suddenly appeared in the fifth month. Eighty-eight ounces of urine were drawn off one morning, although until the night before there had been no difficulty in urination. In labor there was a rather curious anomaly of mechanism —the vertex presented, the occiput was turned forward and to the right, the anterior parietal bone caught on the ramus of the pubis, and the head was laterally inclined, so that the posterior parietal bone descended first into the pelvic inlet and canal. The common Naegele obliquity was reversed. Aside from these two minor complications, there were no difficulties in pregnancy or labor.

The second patient, from the University Maternity, shows a minor grade of the scoliotic obliquely-distorted pelvis. She had congenital syphilis, with some intracranial lesion that determined atrophy and diminished power on the left side. The difference in power between the two sets of spinal muscles has caused a lateral cur-

vature, with the convexity toward the left side. (Fig. 3.) The distortion of the spine necessarily throws the greater weight of the trunk on the left leg, with the same result noted in the preceding case—a displacement of the cor-

FIG. 3.



A scoliotic pelvis.

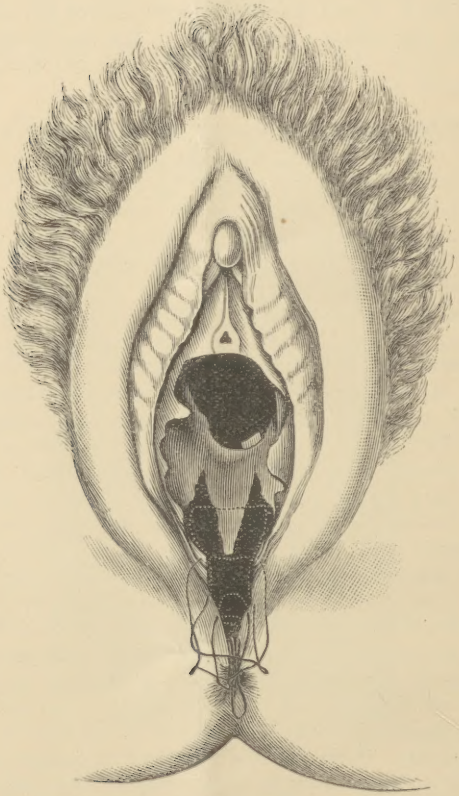
responding innominate bone upward, backward, and inward. This woman is not yet delivered, but I anticipate no special difficulty in labor. A peculiar abnormality at present is a marked lateral tilting of the womb to the left instead of the common inclination to the right side. It was interesting in both of these cases to observe

the relation between the spine of the ischium on the affected side and the nearest edge of the sacrum. In the first case it is one finger's breadth nearer on the deformed than on the normal side; in the second there is about half the distance on the deformed that there is on the sound side.

PRIMARY REPAIR OF LACERATED PERINEUM.

My next patient has a common condition, but one that should interest you. There has been here a laceration of the pelvic floor in labor at some remote period. There is now a large retrocele as the result of the injury to the levator ani muscles and of the stripping off of the vaginal mucous membrane from its subjacent attachments by the passage of the child's head through the vagina. The method of repairing this old injury must now be familiar to you, for we have had already in this clinic a number of modified Emmet operations. I would prefer, if I could, showing you the method of immediately repairing a primary tear. Were this always done properly there would be few opportunities for the secondary operation. In default of cases of primary tears for clinical demonstration, I have had constructed a gigantic model for class teaching (Fig. 4) that is, perhaps, more instructive than a living woman would be. You observe in this model the perineal tear dividing at the base of the posterior column of the vagina and running up both lateral sulci. It is in these sulcal tears that the levator ani muscle is injured. To restore the pelvic floor satisfactorily and permanently it is necessary to bring the fibers of this torn muscle in firm and accurate apposition. To do this it is very rarely necessary to sew up the sulci separately, as is done in the secondary operation, and this is fortunate for several reasons. In the first place, the operation is tedious and painful, requiring an anesthetic and demanding more skill in plastic surgery than is commonly possessed by the general physician. Further, if one places his sttches in

FIG. 4.



Primary repair of lacerated perineum.

he vagina they must be removed after the vaginal and perineal tears are healed—a troublesome and painful procedure. Catgut stitches would obviate this difficulty,

but catgut is not to be depended upon, exposed, as it must be, to the decomposing action of the lochial discharge. The advantages, on the other hand, of the method illustrated on the model are manifold. The stitches are few in number; they can be introduced rapidly and easily, and, tied or shotted on the external perineum, they are easy to remove; an anesthetic is not required in this primary operation, and the ultimate result is perfect if the stitches are inserted deeply enough and with sufficient lateral curve to include a thick bunch of muscle on each side. On this point I can speak with assurance, for I have tested the method thoroughly in hospital and private practice. In the living woman it is necessary to insert, as a rule, two more sutures than are shown in the model, one above and one below the highest stitch. These I have omitted, so as to avoid a multiplicity of sutures that might be confusing. The needle used must be large and well curved. It is convenient to have one set upon a handle, with the eye at the point. This is driven through the tissues threaded with silk wormgut and withdrawn.

UNUSUAL STRICTURE OF THE RECTUM.

The next patient is a woman on whom I operated two weeks ago for a stricture of the rectum. I bring her before you to remove the stitches and to observe the success of the operation. This case interested me much and puzzled me not a little. She informed us that she had been operated upon eight weeks before in another hospital, but for what the operation had been done she could not say. Ever since, she had had great and constant pain in the back, increasing difficulty in defecation, so that she was compelled to take large doses of a laxative every day, and suffered excruciating agony when the bowels did move. On examination, I found a firm, broad annular stricture of the rectum just within the anus, barely admitting the tip of my little finger. There

were two angry fissures in ano, and the whole circumference of the stricture was badly ulcerated. The slightest attempt at dilatation caused unbearable pain, and the results of this treatment did not seem to be promising, in view of the deep ulceration and the possibility of carcinoma, an idea that I then entertained. Consequently, I determined on a radical treatment. The recto-vaginal septum was cut with one blade of a scissors in the rectum and the other in the vagina, until the stricture was well exposed to view. This stricture was then completely excised. The end of the rectum was then brought down and stitched to the anus and the wound closed by rectal and perineal stitches, as though there had been a complete tear of the perineum after labor. I am happy to report to you a complete cure. The wound is firmly united, and in perfect apposition; there is entire control over the sphincter, and no difficulty in defecation. From the time the girl left the clinic-room after the operation she suffered none of her former pain. I have recently had the nature of this case satisfactorily explained to me by the surgeon who first had charge of it. He had performed a Whitehead operation for hemorrhoids while his patient was suffering from acute gonorrhea with a profuse discharge. The area of his operation had been infected and a virulent rectal gonorrhea was the result.